

Healthpoint

Information from the Division of Health Care Finance and Policy

Argeo Paul Cellucci
Governor

William D. O'Leary
Secretary, Executive Office
of Health & Human Services

Division of Health Care
Finance and Policy

Two Boylston Street
Boston, MA 02116
(617) 988-3100

Barbara Erban Weinstein
Commissioner

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Finance and Policy

Welcome to
the tenth
issue
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This is the *tenth edition* of a quarterly publication combining both the data and analytic resources of the Massachusetts Division of Health Care Finance and Policy (DHCFP). Each *Healthpoint* updates trends of general interest and presents a treatment of a health policy issue of current importance to policy makers in the Commonwealth. Past issues have covered home health, hospital mergers and mandated benefits. To obtain copies of back issues or to share your comments and suggestions for future policy topics, please contact the DHCFP Office of Communications: (617) 988-3125.

MASSACHUSETTS HOSPITALS UNDER THE BALANCED BUDGET ACT OF 1997

As its name implies,
the Balanced Budget
Act of 1997 (BBA)

was designed to bring the US government closer to its goal of eliminating the federal deficit. Over three-quarters of the total projected five-year savings of \$127 billion is to be achieved through reductions in Medicare spending. In turn, approximately 30% of the Medicare savings is to be accomplished through reductions in payments to acute care hospitals.¹ In Massachusetts, the Medicare provisions in the BBA are expected to reduce hospital revenue by \$1.4 billion over the next five years. Since Medicare is the single largest purchaser of hospital services, reductions of this size carry important implications for the financial stability of the Massachusetts hospital industry.² This issue of *Healthpoint* assesses the impact of the Medicare provisions in the BBA on acute care hospitals in Massachusetts over the next five years. Special attention is given to the contrasting ability of large teaching hospitals and small community hospitals to absorb the rate reductions.³

Historical Context

The BBA is expected to reduce the annual growth rate in national Medicare spending from the current 8.5% to about 6% by the year 2007. However, Medicare payments to hospitals in Massachusetts have increased at a much slower rate than the national average. In recent years, the rate of growth in per patient charges to Medicare has failed to keep pace even with medical inflation. Since 1993, per patient Medicare charges have risen on average only 1.7% annually, more than one percentage point below the average annual rate of medical inflation. The Commonwealth's hospital profit margin (defined as the difference between revenue and costs divided by revenue) for Medicare patients has also historically been below the national average. A recent study by the Health Care Fi

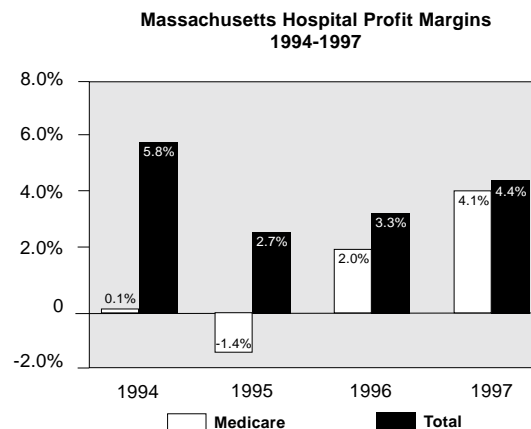


Figure 1

Source: Hospital Cost Reports, Division of Health Care Finance and Policy

nancing Administration (HCFA), the federal agency responsible for administering Medicare, reported that the national Medicare profit margin in 1995 was 10%. State-level data indicate that during the same year Massachusetts hospitals suffered losses of 1.4% on their Medicare admissions (see Figure 1 on page 1). The small and sometimes negative Medicare profit margins have been offset by positive and larger profit margins from private payers. When all payers are counted, Massachusetts hospitals earned profits of 2.7% in 1995, compared to 5.8% nationally.

Hospital financial data reveal three important points for understanding the impact of the BBA cutbacks. First, Medicare payments to Massachusetts hospitals have been declining after adjusting for inflation. Under the terms of the BBA, Massachusetts hospitals can expect further reductions in payments and, therefore, shrinking profit margins net of inflation over the next five years. Second, Massachusetts hospital profit margins are low compared with the rest of the country, providing them less room for adjusting to the rate reductions enacted by the BBA before feeling financially squeezed. Finally, the Massachusetts hospital industry has traditionally been able to absorb low profit margins on its Medicare population by generating higher profits on its private paying patients. A hospital's ability to sustain the BBA cutbacks will depend largely on its share of Medicare patients, and its ability to cross-subsidize these patients by charging higher prices to those who have private insurance—a response that will become increasingly difficult to implement as private payers begin feeling pressure to limit their own expenditure growth.

Medicare Payment Reforms

The BBA reduced the rate of payment for most of the major components of the Medicare hospital reimbursement system. First, the BBA eliminated the hospital base rate update for 1998 and

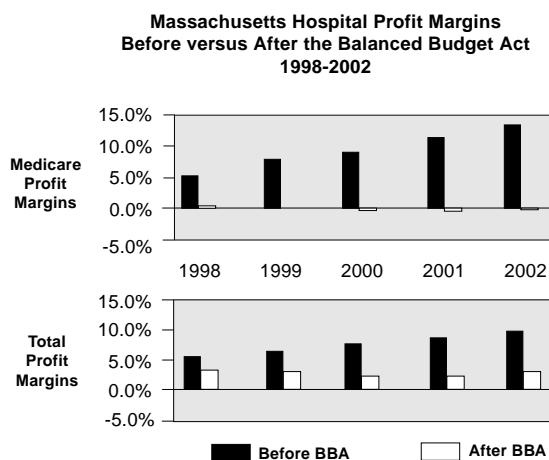


Figure 2

Source: Hospital Cost Reports, Division of Health Care Finance and Policy

fixed it at 1.9 percentage points below HCFA's market basket (MB) in 1999; 1.8 percentage points below MB in 2000; and 1.1 percentage points below MB in 2001 and 2002. Before the BBA, the base rate update (meant to adjust hospital payments for inflation) was scheduled to reflect the full projected change in the market basket. Second, the BBA lowered the rate of payment for capital expenditures permanently by 15.7% and reduced it an additional 2.1% for the next five years. Third, the BBA reduced Medicare reimbursement for uncollected beneficiary co-payments by 45%. Finally, adjustments are made for treating a disproportionate share of poor patients and for providing medical training.

Under the BBA, disproportionate share (DSH) and indirect medical education (IME) adjustments were lowered by 5% and 29%, respectively, over the next five years.

Potential Impact of the BBA

The effect of these rate reductions on Massachusetts hospital profit margins is shown in Figure 2 above. The figure compares projected Medicare and total profit margins under payment regulations before versus after the BBA. The results reveal a widening gap between baseline and BBA profit margins. Without the BBA, Medicare profit margins would have been an estimated 6.3% in 1998. Under the BBA, Medicare profit margins are expected to drop to 0.5% in 1998. By the year 2002,

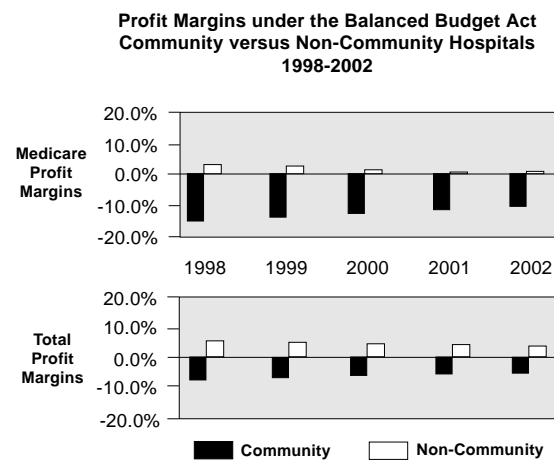
Massachusetts hospitals are expected to suffer losses of 0.1% on Medicare patients under the BBA, compared with a 14.4% Medicare profit under prior regulations. Total profit margins, on the other hand, decline but remain positive following implementation of the BBA. When all patients are included, profit margins fall to an estimated 2.5% during the first year of the BBA. This is three percentage points below projections under prior regulations. Without the policy changes, total profit margins would have risen to almost 10% by the year 2002. Instead, Massachusetts hospitals are expected to earn profits of only 2.3%. The difference between profit margins before and after the BBA represents a cumulative loss of \$1.4 billion over the next five years. This is equivalent to 10% of total hospital revenue between 1998 and 2002.

Community versus Non-Community Hospitals

Hospitals doing well before the payment change will not be seriously threatened by the cutbacks contained in the BBA. However, hospitals struggling to survive prior to these policy reforms will have a more difficult time incorporating the payment reductions. The effects of the payment change will be more onerous on those hospitals with a sizable share of their patient base covered by Medicare. To illustrate the differences in impact, Medicare and total profit margins under the BBA for two hospital groups have been calculated. The first group, referred to as “community hospitals,” consists of the 22 smallest hospitals in the state that do not receive IME or DSH payments. The average number of beds for hospitals in this group is 82. The second group, referred to as “non-community hospitals,” includes the 23 largest hospitals that receive both IME and DSH payments.

Average hospital size in this group is 339 beds. The average share of Medicare admissions in the community hospital group is 53%, and in the non-community hospital group, 39%.

The Medicare profit margin for non-community hospitals is expected to be 3.7% in 1998, falling to 0.6% by 2002 (see Figure 3 above). In contrast, community hospitals are expected to suffer losses on their Medicare patients of 15.4% during the first year of the BBA and losses of 10.9% in five years. When all payers are included, the predicted profit margin for non-community hospitals is 4.8% in 1998 and 3.4% in 2002. These profits are below what non-community hospitals would have earned under the old regulations, but still within sustainable operating margins, especially since Medicare represents a smaller share of their patient population. Even with private paying patients, however, it will be difficult for community hospitals to adjust to the projected revenue shortfall under the BBA. Community hospitals are expected to incur total losses of 7.7% in 1998 and 5.2% in 2002. The financial well-being of small community hospitals, with a traditionally lower level of profit and a higher share of Medicare patients, will be most threatened by the rate reductions mandated by the BBA.



Future Considerations

Under the BBA, all providers (including hospital outpatient departments, home health agencies, skilled nursing facilities, and chronic, rehabilitation and psychiatric hospitals and units) will be

switched to prospective payment systems. In addition, the BBA embraces managed care (including HMOs, preferred provider plans, provider-sponsored plans, religious fraternal benefit plans, and medical savings accounts) as a model for providing health care to its beneficiaries. The first of these reforms gives Medicare a mechanism for controlling the growth in federal health care spending. The second gives the private market greater control over the benefits to be provided. As Medicare moves from a benefit program that guarantees patients a set of health benefits to a contribution program that gives beneficiaries a fixed amount of money to purchase their own health care needs, the potential for quality and access problems, as well as for a shift in responsibility to Medicaid, warrants careful monitoring by the state.

Endnotes

1. Acute care hospitals are reimbursed under Medicare's Prospective Payment System (PPS). Chronic, rehabilitation, psychiatric and specialty hospitals and units within acute care facilities are exempt from PPS and reimbursed under a cost-based system. There are 85 hospitals in Massachusetts reimbursed under PPS.
2. Medicare pays for over 40% of admissions and accounts for over 50% of hospital revenue in Massachusetts. As the baby boomer generation begins entering its retirement years, Medicare's share of admissions and revenue will continue to increase.
3. The analysis presented in this issue is taken from a report prepared by the Massachusetts Division of Health Care Finance and Policy (DHCFP) for the state legislature. The report analyzes the impact of the BBA on all health care providers, as well as on consumers and Medicaid. Copies of this report, *The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid*, are available by calling the DHCFP Office of Communications at (617) 988-3125.

Further Reading

The Impact of Medicare Provisions in the Balanced Budget Act of 1997 on Massachusetts Health Care Providers, Consumers and Medicaid, DHCFP, May 1998.

Report to Congress: Medicare Payment Policy, Medicare Payment Advisory Commission, Washington, DC, March 1998.

An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997, Marilyn Moon, Barbara Gage and Alison Evans, The Urban Institute, Washington, DC, September 1997.

Did you know?

Readmissions Cost More

After discharge from a hospital, a patient is sometimes readmitted within a short period of time for a related illness. Many of these readmissions are preventable with good discharge planning, adequate patient education, patient adherence to prescribed regimens and access to adequate outpatient care. Any hospital admission, particularly when it is for a preventable condition in the first place, is costly to the health care system and undesirable for the patient. Data from the Massachusetts Division of Health Care Finance and Policy hospital discharge database show that charges for related, unscheduled readmissions for congestive heart failure are 30% higher on average than for the initial admission. For bacterial pneumonia readmissions, charges are 26% higher on average than for the initial admission. Here are fiscal year 1996 data on initial admissions and related, unscheduled readmissions for congestive heart failure and bacterial pneumonia in Massachusetts acute care hospitals:

	Congestive Heart Failure	Bacterial Pneumonia
Number of Initial Admissions	17,006	17,416
Number of Readmissions	4,024	2,026
Readmission Rate	24%	12%
Initial Admission Average Charge	\$8,312	\$8,826
Readmission Average Charge	\$ 10,785	\$ 11,157
Initial Admission Average Length of Stay	5.7 days	6.5 days
Readmission Average Length of Stay	6.7 days	7.4 days

Staff for this publication:

Boyd Gilman
Diane McKenzie
Maria Schiff
Heather Shannon

Source: Massachusetts Division of Health Care Finance and Policy Fiscal Year 1996 Hospital Case Mix and Charge Database